THE SALVATION ARMY WISCONSIN SERVICEPOINT

CLIENT CONSENT

This agency participates in the Wisconsin's Homeless Management Information System, which collects basic information about the individuals and households we serve. This data collection is done in order to get a more accurate count of individuals and families who we serve and to identify the need for different services. We only collect information that we consider to be appropriate. The collection and use of all personal information is guided by strict standards of confidentiality. A copy of our *Privacy Notice* describing our privacy practice is available to you upon request. By signing this release you allow your personal information to be shared with other area agencies that participate in the network. Signing this release allows agencies you visit to work in a cooperative manner to provide you with efficient and effective services.

_____ **I give permission for my information to be shared with other participating agencies.**

_____ **I don't give permission for my information to be shared with other participating agencies.**

SIGNATURE **DATE**

_____

ASSESSMENT QUESTIONS

First Name_____ **Middle Initial** _____

Last Name_____ **Suffix**_____

Social Security Number _____ *or check* **(**_____**Don't Know** _____**Refused)**

CURRENT ADDRESS (OPTIONAL):

Address _____

City_____

State_____ **Zip** _____

ANSWER THE FOLLOWING IF YOU ARE PART OF A HOUSEHOLD AND YOUR HOUSEHOLD IS ALSO RECEIVING SERVICE.

3.A. **What is your household type: Check one.**

____Female single parent	____Related caregiver with legal custody
____Male single parent	____Related caregiver without legal custody
____Married couple and child(ren)	____Unrelated caregiver with legal custody
____Unmarried couple and child(ren)	____Unrelated caregiver without legal custody
____Married couple without child(ren)	____Extended Family
____Unmarried couple without child(ren)	____Other

3.B. **Are you the head of your household? Check one.** _____ Yes _____ No

3.C. **What is your relationship in the household?**_____

3.D**. Who is the head of your household?**_____

4. **Date of birth** _____

5. **Are you Hispanic/Latino?** _____ Yes _____ No

6.A. **What is your race**

____ American Indian or Alaska Native (HUD)

____ Asian (HUD)

____ Black or African American (HUD)

____ Native Hawaiian (HUD)

____ Pacific Islander (HUD)

____ White (HUD)

____ Other

6.B. **Secondary Race** *(Optional)*

____ American Indian or Alaska Native (HUD)

____ Asian (HUD)

____ Black or African American (HUD)

____ Native Hawaiian (HUD)

____ Pacific Islander (HUD)

____ White (HUD)

____ Other

7. **Gender** *(Check one.)* ____ Female ____ Male _____ Transgender

8. **Are you homeless?** *(Check one.)* ____ Yes ____ No

9. **Are you single with a disabling condition who has either been continuously homeless for a year or more OR has had at least four (4) episodes of homelessness in the past three (3) years?**

____ Yes ____ No

10. **Where did you sleep the night before coming to this Agency/ Program**. *(Check one that most applies.)*

____A vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside

____Emergency shelter

____Psychiatric hospital or facility

____Hospital (*non-psychiatric*)

____Rental House/Apartment

____Living with family

____Hotel /motel/ SRO

____Domestic Violence Situation

____Non-VA Contracted Halfway Program

____ Don't know

____Permanent housing for formerly homeless persons

____Substance abuse treatment center

____Jail, prison or juvenile detention facility

____Homeownership or Condo Ownership

____Living with friends

____Foster care home or foster care group home

____ VA Contracted Halfway Program

____Other (HUD)

____ Refused to answer (HUD)

11. **How Long Did You Stay in the Place You Were Prior to Entering this Agency/ Program?** *(Check one that most applies.)*

____One week or less

____More than one week but less than one month

____One to three months

____ More than three months but less than one year

____ One year or longer

12. **Zip Code of the Last Place You Lived for 90 Days or More**_____ *or check* **(_____Don't Know _____Refused)**

The Following Questions Are Used To Determine Information about Your Annual Income. Answer the following questions:

13.A. **How Many Individuals Are in Your Household? 1 2 3 4 5 6 7 8**

13.B**. In What County Do You Live?**_____

13.C**. What Is the Your Household's Annual Income?** _____ *or check* **(_____Don't Know /_____Refused)**

14. **Are You a US Military Veteran?** ____ Yes ____ No ____ Don't know ____ Refused

As part of The Salvation Army's efforts to reduce disparities between populations, we are asking clients about smoking and offering resources to those who smoke and would like to quit.

15. **Do You Smoke?** ____ Yes ____ No ____ Don't know ____ Refused

16. **If you smoke, Have you thought about quitting?** ____ Yes ____ No ____ Don't know ____ Refused

17. **If you smoke would you accept a referral for treatment?** ____ Yes ____ No ____ Don't know ____ Refused

18. **Does anyone else in your household Smoke?** ____ Yes ____ No ____ Don't know ____ Refused

19. **Who?** ____ Adult ____ Youth ____ Don't know ____ Refused

The Smoking Quit Line number is as follows: 1-877-270- (STOP) 7867.

20. **Do You Have a Disability?** ____ Yes ____ No ____ Don't know ____ Refused

21. **If you have a Disability, Check all that Apply and Provide a Date for which the Disability Began if Known and Ended if Known.**

Check	**Disability Type**	**Start Date** Fill In Only If You Know the Date for which the Disability Began
	Alcohol Abuse	
	Drug Abuse	
	Developmental	
	Physical/Medical	
	Mental Illness	
	Physical/Mobility Limits	
	HIV/AIDS	

The following items are to be filled out by program staff:

1. **Service Provided or Need Referred**_____
2. **Service Start Date or Referral Date**_____**Service End Date**_____
3. **Name of Staff Person Responsible for Intake**_____